COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: State Retiree Health Benefits Program Participants Who Are Not Eligible for Medicare

From: Mary Habel, Director
Office of Health Benefits

Date: April 7, 2005

Re:
- Open Enrollment
- Your Monthly Premium Rates Effective July 1, 2005
- Important Retiree Group News and Updates

Recipients of this Package - Retiree group participants receiving this package include Retirees, Survivors, Virginia Sickness and Disability Program Long Term Disability (LTD) Participants and some eligible dependents who are covered separately from their spouse or parent.

Open Enrollment - From April 15 through May 16, you have the opportunity to review and make changes to your health plan and membership, including adding or removing dependents and changing your COVA Care optional benefits. Enrollees who live in the Kaiser Permanente HMO service area (in Northern Virginia) may also elect Kaiser coverage. All Open Enrollment changes will become effective on July 1, 2005.

If you wish to maintain your current plan and membership level, you do not need to take any action. Your new monthly premium will automatically be deducted or billed in the usual manner. If your premium is currently deducted from your VRS retirement annuity and the premium increase listed below means that your retirement payment no longer supports the deduction of your monthly premium, direct billing will automatically begin in June for your July premium. **If you decide to make a plan or membership change, see page two, *Making Open Enrollment Changes*, for more information.**

No Change to COVA Care or Kaiser Permanente Benefits - There will be no change to COVA Care benefits, copayments, coinsurance levels or claims administrators, nor any change to the Kaiser Permanente HMO plan on July 1.

New Premium Rates - Listed below are monthly premium costs that will become effective on July 1, 2005.

Plan	*Single Premium*	*Two-Person Premium*	*Family Premium*
COVA Care Basic	**$376**	**$696**	**$1,016**
COVA Care + Out-of-Network	**$385**	**$708**	**$1,032**
COVA Care + Expanded Dental	**$387**	**$718**	**$1,050**
COVA Care + Vision, Hearing and Expanded Dental	**$395**	**$732**	**$1,068**
COVA Care + Out-of-Network and Expanded Dental	**$396**	**$730**	**$1,066**
COVA Care + Out-of-Network and Vision, Hearing and Expanded Dental	**$404**	**$744**	**$1,084**
Kaiser Permanente HMO*	**$371**	**$686**	**$1,002**

*Kaiser Permanente HMO is only available to participants who live in the Kaiser service area in Northern Virginia. If you are a current Kaiser member and do not live in its service area, you must make another plan selection. You may confirm the Kaiser service area by contacting Kaiser directly or going to the Kaiser Web site—see the *Plan Contact Summary* on page four of this correspondence.

New COVA Care ID Numbers and ID Cards - To provide increased security for health plan members, effective July 1, COVA Care participants in the State Retiree Health Benefits Program will no longer use their Social Security Numbers (SSNs) as the health plan identification (ID) number. Your SSN will be replaced with a new, system-generated number. **This means that you will receive all new ID cards.** All vendors will use the same ID number, but your Anthem ID will also include a prefix of YTX before the new ID number. Your enclosed *Open Forum* includes more information about this exciting change. Use your old ID cards through June 30 and present your new cards for services starting July 1. **Kaiser Permanente members will not receive new ID cards.**

Making Open Enrollment Changes - If you wish to make a plan or membership change during Open Enrollment, your completed Enrollment Form must be ***received*** by your Benefits Administrator no later than May 16, 2005, to be effective July 1. An Enrollment Form is enclosed for your use. If you need assistance in identifying your Benefits Administrator, see page one of the Enrollment Form or the enclosed *Plan Contact Summary*. ***All Enrollment Forms must be signed by the eligible Enrollee***; that is, the retiree, survivor or VSDP/LTD participant through whom eligibility is obtained—not by a covered dependent. Even those dependents who have separate/individual coverage, must have their Enrollment Forms signed by the Enrollee. Your Enrollment Form will not be accepted if it is not properly signed by the Enrollee. As an alternative to a paper Enrollment Form, Enrollees may also make changes using EmployeeDirect on the Web—just go to **www.dhrm.virginia.gov** and click on the EmployeeDirect link.

If you are interested in more information about COVA Care optional benefits, consult your COVA Care Member Handbook. If you do not have a Member Handbook, please contact Anthem to obtain additional information. If you would like information about the Kaiser Permanente HMO, contact Kaiser directly. Your *Plan Contact Summary* on page four provides telephone numbers and Web site information.

Making Changes Outside of Open Enrollment - After the Open Enrollment period, membership increases will only be allowed based on the occurrence of a consistent qualifying mid-year event (such as marriage, birth of a child, etc.). Of course, retiree group participants may decrease membership prospectively at any time. Starting July 1, any membership change due to a qualifying mid-year event will also allow for a plan change. If you need more information about making changes to your health plan coverage, a good resource is Retiree Fact Sheet #4, *Making Changes*, which can be found on the Department of Human Resource Management Web site at **www.dhrm.virginia.gov/hbenefits/retirees/nonmedicareretiree.html**. Click on *Retiree Fact Sheets.*

Member Handbooks - You will not receive a complete new COVA Care Member Handbook this year. Instead, all COVA Care retiree group Enrollees and individually-covered dependents will receive a Notification of Changes (amendment) along with their Anthem ID card. Keep your notification with your handbook. Your handbook describes all COVA Care benefits, even those administered by Delta Dental, ValueOptions and Medco. If you need a new handbook, please contact Anthem (see page four for contact information).

Medicare-Eligible Participants Under Age 65 - When a retiree group Enrollee (retiree, survivor, VSDP/LTD participant) or covered dependent becomes eligible for Medicare prior to age 65, an Enrollment Form must be submitted immediately to elect a Medicare-coordinating plan. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage since Medicare becomes the primary payer of claims. If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 plan immediately.

The State Retiree Health Benefits Program will actively seek retraction of primary payments made in error on behalf of participants who are entitled to Medicare benefits but who have not reported that eligibility to their Benefits Administrator. If participants have declined their Medicare Part B coverage, it could result in a delay in Part B enrollment and, as a result, a critical gap in coverage until Part B goes into effect. Please do not overlook your responsibility to report your Medicare eligibility and to enroll in Advantage 65 immediately. If you fail to enroll in Medicare Parts A and B immediately upon your eligibility to do so, the Program will pay claims on a secondary basis as though you had the Medicare coverage to which you were entitled.

Becoming Eligible for Medicare During the Open Enrollment Period - Approximately three months before their 65th birthday, retiree group participants, including covered dependents, receive information about options for selecting a Medicare-coordinating plan available through the State Retiree Health Benefits Program. At that time, if an election is not made, Medicare-eligible members are placed in the Advantage 65 plan. This process continues during the Open Enrollment period, so some members will receive both a Medicare plan enrollment package and an Open Enrollment package. If you become eligible for Medicare prior to July 1, your Medicare plan election will supersede any Open Enrollment election. If you become eligible for Medicare after July, you may make an Open Enrollment election for July 1, and your Medicare plan election will take place on the first of the appropriate month after July.

Prompt Payment of Premiums - Plan participants are responsible for timely payment of their monthly premiums (either through annuity deduction or by direct payment to the carrier). Participants who pay directly to the carrier (Anthem or Kaiser) receive monthly bills or coupons which indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Claims during any period for which premium payment is due but not received will be suspended until payment in full has been received or coverage is terminated for non-payment. This includes prescription drug benefits. Resubmission of any denied claims may be required once payment is made. Once an Enrollee and his/her dependents have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme circumstances and at the discretion of the Department of Human Resource Management.

Participants are responsible for understanding their premium obligation and for notifying their Benefits Administrator within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

Direct Billing of Premiums - For some retirees, an increased premium will mean that the amount of your monthly retirement annuity will no longer be sufficient to cover your monthly premium amount. In those cases, you will begin to be billed directly by Anthem (or Kaiser Permanente, if appropriate). Keep in mind that, due to administrative differences, direct billing occurs in advance of the coverage month, while annuity-deducted premiums are collected in arrears.

Automatic Bank Draft of Premiums - Don't Forget! Retiree group participants who are billed directly by Anthem may now have their premiums automatically deducted from their bank account instead of having to write a monthly premium check. Please contact Anthem (see page four) to obtain enrollment materials for participation in the Automatic Bank Draft program.

Address Changes - Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in your missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record is incorrect. The Department's only means of communicating important information to retiree group participants is through the mail. Please let your Benefits Administrator know when you move! You may also change your address by using EmployeeDirect on the Web at **www.dhrm.virginia.gov**—click on the EmployeeDirect link.

Enclosures:

- Enrollment Form
- ***Open Forum*** Newsletter

Plan Contact Summary

If you have a question regarding benefits, claims or a participating provider, contact the appropriate administrator listed below:

Benefit	*Contact This Administrator*
• **Medical** • **Optional Vision and Hearing**	Anthem Blue Cross and Blue Shield 1-804-355-8506 (in Richmond) 1-800-552-2682 (outside of Richmond) TDD (for the hearing impaired): 1-804-354-4327 (Richmond) or 1-800-554-7752 Web site: **www.anthem.com** (Virginia Members site) BlueCard Worldwide 1-800-810-BLUE (2583) Web site: **www.bcbs.com**
• **Behavioral Health or Employee Assistance Program**	Value Options, Inc. 1-866-725-0602 Web site: **www.achievesolutions.net/covacare**
• **Dental**	Delta Dental Plan of Virginia 1-888-335-8296 Web site: **www.deltadentalva.com**
• **Prescription Drugs**	Medco Health Solutions, Inc. 1-800-355-8279 Web site: **www.medco.com**
• **Kaiser Permanente HMO Participants**	1-301-468-6000 (in Washington, DC) 1-800-777-7902 (outside of Washington, DC) Web site: **http://my.kaiserpermanente.org/mida/commonwealthofvirginia/**

If you have questions about eligibility or enrollment, contact your Benefits Administrator:

If You Are A:	*Contact This Benefits Administrator*
Virginia Retirement System Retiree/Survivor or a Long Term Disability Program Participant	The Virginia Retirement System 804/649-8059 (in Richmond) 1-888-827-3847 **www.varetire.org**
Local or Optional Retirement Plan Retiree or Survivor	Your Pre-Retirement Agency Benefits Administrator

The Department of Human Resource Management Web site also has information about the State Retiree Health Benefits Program. Go to **www.dhrm.virginia.gov**.

Notice

Women's Health and Cancer Rights

In the case of a participant who is receiving benefits under the state's health benefits plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- **Reconstruction of the breast on which the mastectomy has been performed**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance**
- **Prostheses and physical complications during all stages of the mastectomy**